CARE LEVEL II INSTRUCTION MANUAL

INTELLECTUAL / DEVELOPMENTAL DISABILITY/RELATED CONDITIONS RESIDENT REVIEW

Effective November 20, 2015

INSTRUCTION MANUAL FOR CARE LEVEL II PASRR RESIDENT REVIEW I/DD

Effective Immediately
It is extremely important that the screening is typed. KDADS must receive a copy of the assessment that is legible in order to review it and make a determination. Assessments which are not legible will be considered incomplete and returned to Consortium. An actual interview, with the individual being screened, must take place for the assessment to be complete. ALL questions must be answered completely.

The client's name should be clearly written on every page of the assessment and on any attachment.

***Date of Complete Referral to KHS Coordinator**
This is the date that the KHS Coordinator receives the complete referral information requesting a Level II Resident Review.

Date Referred to the Assessor
State the date that YOU (the Level II assessor) received the referral from KHS Coordinator. When you receive the Level II referral, determine whether the client has a legal guardian. By federal law you must contact this individual; you cannot interview the client without this individual present. You should also note other individuals who are involved in caring for this individual and make every effort to involve them in the assessment as well.

Date of Assessment
State the date the assessment is actually done - not the date you fax it to the KHS Coordinator

Date Faxed to KHS Coordinator
This is the date that you FAX the completed assessment to the KHS Coordinator

Previous assessment date
Please identify date of previous screening. The previous assessment date will be provided to you at the time of assignment of the assessment by KHS; you are not responsible for this information.

SECTION I - IDENTIFICATION

Name
Print the individual's name in order of last, first and middle initial.

SSN
Identify the individual's social security number in the space provided. If the client does not know/remember his/her social security number, check his/her available records for the information. Write "unable to determine" if you are unable to determine the client's social security number.

DOB
State the individual's date of birth.

Gender
Identify whether the individual is male or female by placing an "X" in the appropriate section.

Medicaid Number
State the individual's Medicaid number. Please check the individual's chart for this information. If the individual does not have a Medicaid number, state "none". If a Medicaid number has been applied for, state "number pending". Do not leave this question blank.

County of Origin
The following list shall be utilized to establish a home county for a person who is planning to move to a community setting. The list is in priority order.
The county of residence of a family member of the person with Developmental

Disability
Then the residence of the persons guardian or
The county in which the person is living.

Current Location
Include the full name of the facility. This is the name of the facility where the individual is currently residing or is currently a patient. Include the full name of the facility. If same as residential address, state "same" and proceed to Contact person

Ward or Unit
Please give the name of the ward, building, or unit in which the individual is residing if the individual is residing in an institution.

Address
This is the address where the individual is currently residing or the address of the hospital or nursing facility. Please give the complete address, street, city, county, state and zip code. If there is a post office box please list it also.

Contact person
This is the employee at the current facility that is actively involved with the care of this individual. This person when contacted should be able to discuss the current physical and/or mental status of the individual and the steps that have been taken to find a placement for the individual. This person would probably be a discharge planner, case manager, or social worker.

Admission date
This is the date that the individual was admitted to the current hospital or nursing facility.

Phone
This is the phone number where the contact person can be reached.

Fax number
This is the fax number of the hospital, nursing facility, or institution where the person is currently residing at the time of the assessment. Please attempt to determine if there is a fax number for the floor, ward or unit where the individual is residing, rather than a general institutional number.

Attending Physician Name
State the physician's first and last name. This person will not necessarily be the primary physician. If the individual has multiple physicians, state the physician who is caring for their immediate needs. Please attempt to ensure that your information is not outdated.

Phone
This is the phone number for the attending physician. Please give it in its entirety.

Address
State the complete mailing address for the attending physician, including the city, state and ZIP code. Give PO Box if there is one. A copy of the outcome letter will be sent to the physician.

Proposed Facility (if applicable)
If a change in residence is being proposed at the time of this RR, identify the facility where the individual intends to reside. State the facility's complete name. If the location is unknown, state "Not Yet Determined". Please be specific, i.e. do not write "Medical Haven", but be sure to clarify by stating "Medical Haven - Elkhart".

Address
State the complete address of the proposed facility. Give the street, city, county, state, and zip code. Give the PO Box if there is one.

Phone number
Identify the proposed facility's telephone number, including area code.

Fax Number
This is the fax number of the admitting facility, including area code. Please check to be sure that it is the correct fax number.

Proposed date of Admission
Please give the proposed date of admission to this facility.

Contact Person
Please give the name of a person who can be contacted at the proposed facility for information regarding this patient. This is also the person that any fax communications will be addressed to. This individual could be a case manager, social worker, director of nurses, etc.

Please give the following information about any individual serving as Guardian*; DPOA; Other Legal or Medical Representative

Using the definitions given below, please mark the appropriate legal representative that this individual has to assist with his/her health care needs.
A Guardian is an individual who is legally responsible for the care and management of an individual, as appointed by a court of competent (probate) jurisdiction. A guardian may also be responsible for the care and management of an individual's medical decisions and/or property. A designation as "authorized representative" or as the individual with "power of attorney" is not equivalent to a designation of guardian.

***Attach copy of signature page of the court's guardianship order, if available**
In the case of guardianship, please photocopy the signature page of the guardianship order and attach to the assessment questionnaire.

DPOA refers to a durable power of attorney. The DPOA may be either a power of attorney for medical care or a general power of attorney. In either case, the individual is fully capable of making his/her own decisions.

Other Legal or Medical Representative involvement may include an individual with power of attorney, an authorized representative, an attorney, or a physician.

Name
Identify the name(s) of person(s) specified as legal representative of this individual.

Address
Identify the full address of person(s) specified as legal representatives of this individual. Please give the street, city, state and zip code. If the individual has a PO Box listed, please include it.

Home Phone Number
Identify the home telephone number including area code of the person specified as a legal representative of this individual.

Work Phone Number
Identify the work telephone number including area code of the person specified as a legal representative of this individual.

Does the individual have another person involved in a significant way, from whom we may be able to obtain additional information about the client's social, medical, emotional, or environmental history and status?

Yes _____ No _____

Please mark the appropriate response.

If yes, please provide the following information:

Name
Print the person's full name.

Address
Print the person's complete mailing address, including street, city, state, zip code. If there is a PO Box, please give it.

Home phone number
Please give the home phone number, including area code, where this person may be reached.

Work phone number
Please give the work number, including area code, where this person may be reached during the day.

Relationship to individual
State the person's relationship to the individual, i.e. friend, mother, spouse, etc.

SECTION II - DIAGNOSIS & EXCLUSIONS

1a. **Has the diagnostic picture changed since the last assessment?**
KHS will supply you with a copy of the previous assessment, if available, which lists the diagnoses at that time. If there was not a previous assessment in the individual's file, KHS may ask you to fill in this information from the history in the individual's current file. If this is necessary, please provide us with this information to the best of your ability. Please list the changes.

1b. **Does the individual have a diagnosis of Intellectual/other developmental disability listed as defined on the next page?**

The definition of Intellectual Disability is as follows:

Intellectual Disability refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. A person is considered to have mental retardation if he or she has a level of retardation (mild, moderate, severe or profound).

For purposes of this assessment the **definition for Other Developmental Disability follows**:

Other developmental disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment (or a condition which has received a dual diagnosis of mental retardation and mental illness) and is evidenced by a *severe, chronic disability* which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, AND

2. is *manifest before the age of 22*, AND

3. is likely to continue indefinitely, AND

4. results in substantial functional limitations in any three or more of the following areas of life functioning:

    a. self-care,
    b. understanding and the use of language,
    c. learning and adapting,
    d. mobility,
    e. self-direction in setting goals and undertaking activities to accomplish those goals,
    f. living independently,
    g. economic self-sufficiency, AND

5. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, AND

6. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

The definitions follow:

Self Care
Performance of basic personal care activities.

Language
Receptive and Expressive. Communication involving both verbal and nonverbal behavior enabling the individual both to understand others and to express ideas and information to others.

Mobility
The ability to move throughout one's residence and to get to, access and utilize typical settings in one's community.

Learning
General cognitive competence and ability to acquire new behaviors, perceptions and information, and to apply experiences in new situations.

Independent living skills
Capacity for independent living. Age appropriate ability to live safely without assistance from other persons; includes housekeeping, participation in leisure time activities, and use of community resources.

Self direction
Management and taking control over one's social and personal lives. Ability to make decisions affecting and protecting one's own interests.

Economic Self-Sufficiency
The ability to pay for basic needs and services through employment or other financial resources.

2. **Does the individual have a primary diagnosis of dementia or a dementia-related disorder (also called neurocognitive disorder)**
Yes _____ No _____

Place an "X" beside the appropriate response. If "yes", please list the diagnosis. This information should be available in the individual's records. If you have a question as to where dementia is currently fitting into the priority of diagnoses, please consult with the doctor or staff (RN or social worker). For the purposes of clarity and diagnostic accuracy, a brief discussion of dementia is included in this manual, but does not substitute for a thorough knowledge of and familiarity with the disease. In the majority of the cases, the diagnosis of dementia, if applicable, will already be identified. In the event dementia has not been identified and you suspect such a diagnosis, note this on the assessment, **BUT DO NOT ATTEMPT TO MAKE A DIAGNOSIS AS PART OF THIS ASSESSMENT.**

Examples of dementia and related disorders include: Multi-infarct Dementia, Parkinson's Disease with Dementia, AIDS-related Dementia, Alzheimer's Disease, Senile Dementia, Korsakoff's, Dementia related to alcohol/substance abuse, dementia related to a physical condition, etc. *Please note, in order for an individual to meet this qualification, Dementia must be listed as part of the diagnosis (i.e. Dementia, due to Parkinson's Disease, or Dementia secondary to Parkinson's Disease, not just Parkinson's Disease).*

If you are marking yes, this means the individual will be exempted from future PASRR due to the diagnosis of Dementia.

You must provide verification from clinical records which document dementia as the primary diagnosis. The required documentation may be in the form of the history and physical, the psychiatric evaluation, discharge summary, progress note updates, medication sheets or care plans that shows the dementia as the primary diagnosis. Any

psychological or neurological testing (MRI, PET or CAT Scan, etc.) that is available to you that supports the dementia diagnosis should be faxed in also.

If the answer to # 1b is No or # 2 is Yes, the Resident review assessment is finished. Please proceed to the Clinical Summary section on page 8 and also answer questions # 20, 21 and 22.

3. **Does the individual have medical condition which is**:

Permanent Yes _____No _____Progressive Yes _____No _____

Mark the appropriate answer for each category.

***Permanent:**

Permanent infirmities of aging are identified as the current primary factor causing the individual to need twenty-four hour nursing care AND the individual will no longer benefit from specialized services for persons with mental retardation or related conditions.

***Progressive:**

A medical condition of a progressive degenerative nature which, due to the current increasing deterioration directly related to the condition, is a primary factor determining the need of the individual AND the individual can no longer benefit from specialized services for persons with mental retardation or related conditions.

*Permanent and Progressive related exemptions require a Level II Assessor to initiate an assessment and make the determination regarding the status of the individual's condition. Documentation is required to be maintained.

4. If the response to any of #3 a is yes, please describe the medical condition and the treatment required.

You must state the specific illness and all required treatments which are related to that illness.

If you answer "Yes" to # 3, the Resident Review is aborted. Please provide supporting documentation and proceed to the Clinical Summary section on page 8 and also answer questions # 20, 21 and 22.

SECTION III - SUMMARY OF TREATMENT SINCE LAST REVIEW

Please attach the most recent MEDICAL HISTORY AND PHYSICAL. The review cannot be accepted without this document and will be counted as an incomplete assessment. If you cannot obtain the history and physical, please contact the Consortium Coordinator.

Photocopy the individual's most recent medical history and physical; this history and physical should include information regarding the individual's neurological status in the areas of motor functioning, sensory functioning, deep tendon reflexes, cranial nerves and abnormal reflexes.

This history and physical should have been completed within the last year. However, if the most recent one is older than a year, submit it with a recommendation that the medical history and physical needs to be updated. Sometimes the updated history and physical can be found on progress notes if the individual is currently a resident in a long term care facility.

If the assessment is being done in a home setting, try to obtain a history and physical from the local physician. The physician should already be involved with the referral, since a physician's order is necessary for admission to the nursing facility. If it is after hours or on a weekend, please ask the client or their guardian to sign a release of information for ADRC to obtain the history and physical and fax the release to ADRC. The ADRC has said that they will try to help their assessors in obtaining this information.

The Resident Review is a two stage process. First, a thorough chart review is necessary. Second, an interview with the client is required. Explore changes that may have occurred in the client's social and physical environment. Note changes in affect and mood. Review the client's psychosocial history over the past year and their current functional abilities.

Sample questions to ask during this interview include:

- How has the last year been for you?
- What changes have taken place in the last year? - Are you happy living here?
- What do you like about living here?
- What problems have you had this year?
- How has your health been?

The client's opinion and self-assessment is an essential portion of the review. Do not "cut corners" in the interview.

5. **Please describe any changes in living arrangements, including hospitalizations that have occurred since the last review. State dates and the reasons for these changes.**

   Review the records and interview the individual and staff and describe any type of changes that occurred. Examples might be, but are not limited to: change in nursing facility, admission to a psychiatric or medical hospital, change in type of room (private to semiprivate) or community placement was attempted. If a change has occurred, please give the reason for this change, such as exacerbation of mental illness (describe the behavior), what the medical problem was, why a room change was necessary. If community placement was attempted, why did it fail? Please give the dates of the change.(s).

6. **Please describe the current physical condition and medical needs of this individual Include any special treatments and equipment this individual requires (i.e. needs wheelchair, walker, cane, oxygen ,needs to be fed, falls easily, short of breath, frail, etc.)**

Please discuss the current physical status of this individual and his/her medical needs at this time. Include observations of his/her physical condition and how it affects his/her ability to care for themselves. Include significant medical needs or special treatments such as, but not limited to, physical therapy, oxygen, injections, dialysis, wheelchair, walker, meal supplements, technological assistance, etc.

6a. **Have there been any changes in the physical condition since last review?**

Yes _____ No _____

If Yes, please describe:

Describe the medical/ physical changes (both positive and negative) that have occurred since the last review and the treatment needed. Is the individual now incontinent with catheter, has COPD worsened and O2 is needed or is the individual now improved and able to transfer on their own, etc.

7. **List all medications the individual currently takes including over-the-counter medication and indicate whether the medication is:**
S = Stable or A = being adjusted.

Medication	Dosage/Frequency	Route	S/A

Medication

This information is contained in the individual's records and also may be verified by verbal report. Please include all medications, not only those medications relevant to the presenting problem. Specify the name of the medication (either trade or technical). Be specific, i.e., do not identify "anti-depressant" rather state "Prozac, Anti-depressant." Also indicate whether the medication is over-the-counter, "self-prescribed," (taken without close monitoring or instruction from physician) or physician prescribed.

Dosage and Frequency

Indicate the dosage: dosage refers not only to the amount in terms of milligrams, but also the frequency (i.e. three times a day, as needed, etc.).

S/A

Indicate also whether the dosage identified is stable, or in the process of being adjusted. This information should be available in the client's records. Stable medications generally have been at a set dosage for a significant period of time to adequately treat the condition. Medications being adjusted will be new medications and/or be in the process of raising or lowering the dosage. For new prescriptions, identify the length of time the individual has been taking the dosage.

Route

Indicate using the following abbreviations:

P.O. = by mouth	IM = intramuscular
SubQ = subcutaneous	S.L. = sublingual
IV = intravenous	Top = topical

Common abbreviations for time:

Qd = every day	BID = twice daily
TID = three times daily	QID = four times daily
a.c = before meal	p.c. = after meal
qod = every other day	prn = as needed
1M = one time per month	hs = hour of sleep
q4h = every four hours	q6h = every six hours
am = morning	pm = afternoon

7a. **Has there been a change in medication since last review?**

Medication	Dosage/Frequency	Route	S/A

Follow the same procedures as outlined in question 15. Include all new medications that have been prescribed since last review and/ or change in dosages of presently prescribed medication Include information if and when a medication was discontinued and, if applicable, why the medication was discontinued.

8. Have the recommendations listed in the PASRR Level II approval letter been addressed?

Yes _____ No _____

Please explain:

Kansas Department of Aging and Disability Services offers recommendations in their PASRR Level II approval letter in both situations, Pre-Admission Screening and Resident Review. Please review the most recent approval letter to determine if the recommendations have been addressed. If recommendations have not been addressed provide explanation why they have not. You must attach a copy of the PASRR Level II approval letter that lists the recommendations. KHS will provide you with the copy of the letter if there has been a previous assessment.

SECTION IV - CURRENT LEVEL OF FUNCTIONING

9. **Enter the code for EACH activity of ADL that indicates the average level of functioning for this individual during the course of the day in their present setting.**

In completing this section of the assessment, you will be making determinations concerning the individual's ability to function in their environment. It is essential that you obtain the necessary information from a variety of sources to make an accurate determination of the individual's level of functioning.

Observe the individual during the interview process. Talk with family members and clinical staff. If the individual is in a hospital setting or other health care facility talk with staff. The individual's ability to function may vary over the course of a day. Code for the average level of functioning during the day.

If the individual uses an assistance device to perform an activity, code the client's ability with the use of the assistance device. Indicate in the comment section any assistance devices used by the client to perform an activity of daily living.

Indicate areas of changes, both improvement and decline and/or if no change has taken place since the last review by placing a check mark in the box. For those areas checked, where there has been a change, provide a detailed explanation in the space provided.

Coding

1 = Independent: Individual is able to accomplish the task independently. This means the individual would be able to accomplish the task without any assistance, cueing, or reminding. If an assistive device is used, such as a walker, but the individual requires no assistance in using or maintaining it, code as 1 and "uses walker" in Comment Section.
2 = Supervision needed: Supervision is needed for the client to accomplish the task. This includes cueing, reminding or oversight. Oversight includes preparing the bath water, handing the wash cloth, watching that a person with dementia doesn't choke, watching as an individual transfers from chair to bed or toilet, etc.
3 = Physical Assistance needed: The individual requires physical assistance from another person in order to accomplish the task safely.
4 = Unable or unwilling to perform: Individual requires full assistance from at least one caregiver in order to accomplish the task or client refuses to perform any part of the task.

It is important to think about "hidden" cues which may be present, such as the meal being placed in front of a person may be their cue that they need to eat. Ask yourself "would they remember to eat if the meal was not set in front of them?"

ADL's (Activities of Daily Living)

Bathing

Definition: How the individual takes a full body bath or shower, or sponge bath, and transfers in and out of the tub or shower. Does not include washing back and hair.

Coding: **1 = Independent** - Able to bathe self without assistance.
2 = Supervision needed - Requires oversight help only. Oversight includes reminding, preparing bath water, handing individual wash cloth. Individual able to transfer into shower or tub and can bathe self with cuing and oversight.
3 = Physical assistance needed - Individual requires physical assistance getting into bathtub and shower and/or requires some assistance with bathing.
4 = Unable to perform - Individual unable or unwilling to perform any part of the task of bathing.

Dress Appropriate

Definition: How the individual puts on, fastens, and takes off all items of clothing, including donning and removing a prosthesis.

Coding: **1 = Independent** - Individual is able to select appropriate clothing and dress self without any assistance. Individuals who use a prosthesis are able to apply and remove the prosthesis independently.
2 = Supervision needed - Individual requires oversight, cuing or encouragement to select and/or put on appropriate clothing. Individual requires cuing or oversight to put on a prosthesis.
3 = Physical assistance needed - Individual able to perform part of the task of dressing, but requires physical assistance such as guided maneuvering of limbs or other physical assistance.
4 = Unable to perform - Individual is totally dependent on another person for all aspects of the task of dressing.

Toileting

Definition: How the individual uses the toilet (or commode, bedpan or urinal), transfers on and off the toilet, cleanses, changes pads, manages ostomy or catheter, adjusts clothing.

Coding: **1 = Independent** - Individual is able to perform the task of toileting without assistance, oversight or cuing.
2 = Supervision needed - Oversight, cuing or encouragement required to ensure individual can perform the task of toileting.
3 = Physical assistance needed - Individual may be highly involved in the task of toileting, but physical assistance is required to assure that the task is performed safely. Physical assistance may include adjusting clothing, transferring to and from toilet, help using a urinal or bedpan.

4 = Unable to perform - Individual requires assistance with all tasks related to toileting.

Transfer

Definition: How the individual moves between surfaces: to and from bed, chair, wheelchair, standing position. Do not include moving to and from bath or toilet.

Coding: **1 = Independent** - Individual able to transfer self without cuing, oversight or physical assistance
2 = Supervision needed - Oversight, cuing, or supervision was required
3 = Physical assistance needed - Although the individual may be involved in the process of transferring, help was provided such as guided maneuvering of limbs or weight bearing.
4 = Unable to perform - Individual requires full assistance of at least one care giver when transferring.

Walking/Mobility

Definition: Means the ability to move between locations in the individual's living environment. Do not include ability to walk or be mobile outdoors.

Coding: **1 = Independent** - Individual requires no oversight, cuing or encouragement to ambulate. Individuals who use a wheelchair are able to be mobile without assistance from another person.
2 = Supervision - Individual requires cuing, oversight or encouragement to ambulate or to be mobile in a wheelchair.
3 = Physical Assistance needed - Individual requires the physical assistance of one or more persons to walk safely. Individual uses a wheelchair and requires another person to move the chair from one place to another.
4 = Unable to perform - Individual unable to perform any of the tasks related to ambulation. Use this code for individuals who are bedfast and do not use a wheelchair or other mobility devices.

NOTE: If the individual has a recent history of falls, it is unlikely that they are independent in walking.

Eating

Definition: How the individual eats and drinks.

Coding: **1 = Independent** - Individual able to eat and drink without any cuing, oversight or encouragement.

2 = Supervision - Oversight, cuing or encouragement required to ensure individual eats. Supervision includes ensuring that individuals with dementia eat appropriate food items.

3 = Physical assistance needed - Although individual may be actively involved in the task of eating, physical assistance by another person is required for some of the tasks related to eating.

4 = Unable to perform - Individual unable to perform any of the tasks related to eating and is dependent on a care giver for nourishment. Use this code for individuals who receive their nourishment via intravenous therapy or a feeding tube and are dependent on another individual for the preparation and administration of the feeding.

10. **Please answer the following questions related to communication**

a. **Can the individual effectively communicate needs to staff?**

Yes _____ No _____

b. **Is he /she easily understood?**

Yes _____ No _____

c. **Is the individual able to maintain a conversation?**

Yes _____ No _____

Observe individual during the interview and ask persons involved in individual's treatment how she/he communicates.

11. **Is the individual able to self-administer and schedule medical treatments, self-monitor health and nutritional status?**

Yes _____ No _____

Place an "X" beside the appropriate response.

This question refers to the individual's ability to seek medical treatments and schedule appointments when appropriate. Also addressed in this question are the individual's ability to assess their health status, such as a diabetic's ability to monitor their blood sugar.

It also refers to an individual's ability to follow a reasonably healthy diet, that is, can they maintain adequate nutrition? This addresses the individual's ability to obtain a sufficient caloric intake, following prescribed diet guidelines as applicable (such as restricting levels of sugar, sodium, fats, etc.). Again, a continuum exists regarding this ability and jeopardizing one's health is the determining factor for this item.

SECTION V - LIVING ARRANGEMENT AND SUPPORT NETWORK

12. **Indicate the individual's preferred living arrangement? (individual's choice, not service provider's recommendation):**

Ask the client where she/he prefers to live and the reasons for this preference. Record this information. If the individual is uncertain or unable to offer a preference, please so indicate. Do not assume a response from the party.

13. **If there is a legal guardian, do they agree with the individual's choice of living arrangement?**

The guardian must be consulted! Please indicate guardian's preference and reasons for this preference.

14. **Indicate current and past resources used:**

Currently has a home or apartment available

	Yes		**No**	

Has lived independently or semi-independently in the past.

	Yes		**No**	

How recently?_____ **For how long?**_____

Has individual received MR/DD services?

	Yes		**No**	

Name of CDDO or service provider:_____

Indicate by checking "Yes" or "No" to the above questions. If individual has lived independently or semi-independently in the past, please write down how recently this was and what the duration was. Name the CDDO or service provider that has served individual in the past or currently serves the individual.

15. **Individual's Support Network includes:**

Family Members
Identify: Case Manager
Identify: Guardian or Payee
Identify: Others

Check available supports and provide specific information (Names and phone numbers, availability, etc.). In space provided clarify level of involvement of identified supports.

16. **Is transfer to a community-based setting reflected in the current plan of care? Give date of proposed discharge from the facility:**

Yes _____ No _____ Proposed Date: _____

Please discuss this with the staff, in order to determine if a smooth and successful transition can take place. This is very important in the determination process. If placement is going to take place in the near future, then the recommendation for no nursing facility is appropriate. However, if you believe the individual has reached a level of functioning that warrants consideration of community based placement and that process is not yet in place, please consider the impact that it will have on the resident and his/her chances of a successful placement. If that process is not in place, please consider a recommendation that the nursing facility staff, the resident and legal guardian (if appointed) in alliance, initiate active pursuit of transition to a community setting with community support services.

17. Please list the reasons why this individual continues to need 24-hour nursing care. Take into consideration medical, physical and/or functional needs which require the level of care provided in a nursing facility:

Describe those medical, physical and/or functional needs that require 24-hour care in a nursing facility. These are areas that demonstrate the necessity for 24-hour nursing care or supervision in order to provide medical care and safety for this individual.

18. **Support Services and Resources that may be used to assist the individual to live successfully in the community living arrangement of their choice (check all that apply and indicate whether they would be available, not available or unknown):**

Needed		Available	Not Available	Unknown
D	Affordable housing or housing subsidy			
D	In home support (estimated hours per day or week)			
D	Case management service to assist with goal planning, mobilizing community supports, problem solving, assisting the individual to learn to use available resources and crisis intervention.			
D	Respite available as needed			
D	Wellness monitoring			
D	Meals-on-Wheels or other nutritional program			
D	Natural supports: such as family, roommates, friends, church, etc.			
D	Residential services			
D	Day services			
D	Recreational activities			
D	Supported employment			
D	Medical Assistance			
D	Assistive devices			
D	Nursing care (Visiting nurses in community)			
D	Other services (List):			

Indicate which services individual would need to successfully reside in the community.

Mark whether the service is available in the community, not available or unknown. See attached pages (at the end of the manual) that define Residential services, Supportive Home Care, Day Services, Wellness Monitoring, Night Support, Respite Care and Communication Devices.
This information should include how much of the service is needed.

☛ **Please list CDDO responsible for arranging these services**

SECTION VI - CLINICAL SUMMARY

The clinical summary should integrate information obtained through a review of the records and clinical interviews. The summary of information relayed in this section should support your recommendation for the level of care indicated on question # 19.

If you do not concur with diagnosis on the record (you believe the diagnosis does not reflect the individuals current condition) state that you disagree and why. It would then be appropriate to recommend a reevaluation of diagnosis in question # 20.

SECTION VII - FINAL RECOMMENDATIONS

19. **Mark the appropriate placement/service recommendation:**

___ Nursing facility level of care **is** needed/Specialized mental retardation services **are not** needed.

___ Nursing facility level of care **is not** needed/Specialized mental retardation services **are** needed.

___ Nursing facility level of care **is not** needed/Specialized mental retardation services **are not** needed

The assessor should use clinical judgment in making this recommendation. Stringent guidelines are not appropriate; consider individual differences and conditions. Use the following definitions for nursing facility and specialized services in making your recommendation:

For purpose of this assessment:

Specialized Services for individuals with I/DD or Other Developmental Disability is defined as those services which necessitate the availability of trained I/DD personnel from a KDADS licensed provider. These services can be provided in the following settings:

1. Intermediate Care Facility for Mental Retardation (ICF/MR);

OR

2. Community setting if the services provided are equivalent to the level of services provided in an ICF/MR.

Nursing facility: "any place or facility operating for not less than 24 hours in any week and caring for six or 0more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and

treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care."

20. **Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. As a QIDP, please provide any additional recommendations for support services to meet the individual's needs (such as: review of medications, reevaluation of diagnosis) and why these services are recommended:**

As a qualified intellectual/developmental disability professional your recommendations are an important piece of the PASRR process to insure that the individual with developmental disability/related condition are receiving those services which are necessary to meet their developmental disability needs. A copy of the assessment that you conducted will be supplied to the nursing facility so that your recommendations can be included in the care plan for this individual. They will also be included in the recommendation section of the determination letter (copies of which will be supplied to the NF, doctor and guardian).

Make service recommendations based on a thorough knowledge of resources available in the community in which the individual will be residing in. Obtain this information through community networking and written resources. Your local community developmental disability organization (CDDO) is an excellent resource.

21. **What resources were utilized to gather information for this assessment? Include names of individuals and title.**

Every effort must be made to contact and involve the guardian in the assessment. If the guardian declines involvement or is unavailable, please explain why in the remarks section of this question.

Individual (face to face) and exact location where assessment took place:
Enter name of individual and date of interview with client. The individual must be interviewed or at least observed in person, (if the individual has a condition which would be exacerbated through conduction of a personal interview). If the individual cannot be a part of the assessment, call your KHS Coordinator immediately.
Please also give a description of where this assessment took place. For example: Individual's room, day hall, etc. Give the name of the facility where the interview took place, or if it was in the individual's home, state this.

Guardian and date interviewed:
Enter the name of the Guardian that you talked with and the date interviewed. Indicate if the interview was in person or by phone. If you did not talk with the guardian, document why this was not done, or document that guardian was notified by you and declined to attend interview.

Family Members:
Enter the names and relationship of those family members you interviewed in order to obtain information for this assessment. Family members should be notified prior to assessment and given an opportunity to be involved. If family members were not involved, explain why.

Health Care Professionals (must be interviewed and listed):
Enter the names and titles of those health care professionals that you interviewed in order to obtain information for this assessment. Case manager or discharge planner must be included.

Clinical Records:
List those clinical records, by name and date, that you accessed in order to obtain information for this assessment. Examples: Current file (should include orders, progress notes, history and physical, medication sheet, etc. If client is already a resident in the nursing facility Minimum Data Set (MDS) must be reviewed).

Minimum Data Set (ADS) Version 2.0:
Please note the date of the last Minimum Data Set (MDS) that you reviewed for this assessment. During the conversion to the MDS 2.0 from the MDS+, the most recent instrument should be reviewed and listed.

Remarks:

SECTION VIII - QMRP SIGNATURE

22. **Assessor's name**
Print your full name (first, middle initial, last) and title (Ph.D., MD, RN, MST., etc).

Assessor's work phone number(s)
Provide the telephone number(s) at which you are most accessible during daytime and early evening hours.

Date
Date the form, only after it is completed in full and is ready to be forwarded for further review.

Assessor's license type and number
Specify your license type and number.

Assessor's signature
Sign the form, only after it is completed in full.

23. **Is this PASRR Level II a courtesy assessment?**

Mark Yes_____No _____

A courtesy assessment is a assessment performed by a assessor from one CMHC on a person who is either (1) a current consumer of another CMHC, or (2) a person for whom another CMHC is responsible based upon that person's "county of responsibility", refer to page 3 of this manual. When assessor learns that a person being assessed is or should be a client of another CMHC, that Center should be contacted. If an immediate contact is not possible, then the PASRR Level II may be continued and the situation will be discussed with staff of that Center as soon as possible.

During the discussion with staff of the CMHC responsible for the person being assessed, the responsible CMHC's staff person should either: (1) arrange to complete the assessment by sending the assessor to the location of the person or by utilization of some other method, such as interactive TeleVideo, or (2) arrange for the screening to be completed by a assessor from the contacting CMHC. This alternative is referred to as a "courtesy assessment."

A courtesy assessment is commonly required when the person's "county of responsibility" falls within the service area of a CMHC other than the one within which the person comes to the attention of the local assessor.

An important aspect of any PASRR Level II is a knowledge of the resources of the person's home community. Since the person performing the courtesy assessment may not be familiar with those resources, "matching" the person's assessed needs with the resources of the home area will be difficult. The assessor must make every effort to contact the responsible CMHC in order to obtain necessary information. If the person being screened does not intend to return to their "home" community, then the assessor will need to match local resources with the person's assessed needs.

In any case, a copy of the screening instrument and any admission authorization documents must be faxed to or otherwise sent to the CMHC which has responsibility for that consumer. In the event that agreement cannot be reached as to which CMHC has responsibility for an individual, the CMHC originally requested to perform the screening must complete that screening and accept temporary responsibility for that consumer. Thereafter, the state mental health authority shall make the final determination.

Date Faxed to responsible CMHC:

Indicate date faxed to responsible CMHC

Contact Person at responsible CMHC:

Indicate staff person at the responsible CMHC who the assessor spoke with about the individual being assessed.

24. <u>Time Documentation Summary:</u>

Screen Time:	__	Hours	__	Minutes
Travel Time:	__	Hours	__	Minutes
Total Time:	__	Hours	__	Minutes

Please document the time it took to complete the screen in hours and minutes, whether it was completed in its entirety or aborted.